MDR Tracking Number: M5-04-0508-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-17-03.

The IRO reviewed office visits, joint mobilization, myofasical release, manual traction, and unlisted neurological or neuromuscular diagnostic whole procedure rendered from 07-16-03 through 07-31-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for, manual traction, and unlisted neurological or neuromuscular diagnostic whole procedure.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for office visits, joint mobilization, and myofasical release. Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($2224.00). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-31-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
07/02/03	99213	$48.00	0.00	No EOB	$48.00	MFG E/M GR (IV)(C)(2)	Soap notes confirm delivery of service as billed. Recommended Reimbursement $48.00
	97265	$43.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service as billed. Recommended Reimbursement $43.00

	97250	$43.00	0.00		$43.00	MFG MGR (I)(C)(3)	Soap notes confirm delivery of service as billed. Recommended Reimbursement $43.00
	97122	$35.00	0.00		$35.00	MFG MGR (I)(A)(10)(a)	Soap notes confirm delivery of service as billed. Recommended Reimbursement $35.00
	97110 (4 units)	$140.00	0.00		$35.00 per unit	MFG MGR (I)(A)(9)(b)	See Rational below
TOTAL		$309.00					The requestor is entitled to reimbursement of **$** 169.00

RATIONALE

Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended

This Decision is hereby issued this 5th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 8-28-01 through 12-28-01 in this dispute.

This Order is hereby issued this 5th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **Amended Letter**
Note: Decision

December 23, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: MDR Tracking #: M5-04-0508-01
IRO Certificate #: IRO4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___'s health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
This patient sustained an injury to her right hand on ___ when it was crushed by a hot press. She saw a chiropractor for treatment and therapy to improve her range on motion (ROM) in the right hand.

Requested Service(s)
Joint mobilization, office visits, manual traction, myofascial release, therapeutic exercises, and unlisted neurological or neuromuscular diagnostic whole procedure from 07/16/03 through 07/31/03

Decision
It is determined that the joint mobilization, office visits, myofascial release, and therapeutic exercise from 07/16/03 through 07/31/03 were medically necessary to treat this patient's condition. However, the unlisted neurological or neuromuscular diagnostic whole procedure and manual traction were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision
The patient was involved in a crushing injury to the right 1st and 2nd digits. Given the highly repetitious nature of the employee's work duties, it is vital that an adequate course of rehabilitation applications be administered to minimize the possibility of future injury.

The provider implemented a rehabilitation program designed to restore motion and function to the right hand/wrist/fingers and the upper quarter motor chain. An eight week program is medically necessary and appropriate, given the mechanism of injury.

The provider's utilization of an unlisted neurological test like Current Perception Threshold (CPT) is not appropriate. CPT has been shown to be of use in the detection of peripheral nerve integrity and in the detection of carpal tunnel syndrome (CTS). There is no examination qualification that would suggest that this patient has CTS or that there is a problem with peripheral nerve integrity. Implementation of manual traction is redundant and can be classified under mobilization in this body region. Therefore, it is determined that the joint mobilization, office visits, myofascial release, and therapeutic exercises from 07/16/03 through 07/31/03 were medically necessary. However, the unlisted neurological or neuromuscular diagnostic whole procedure and manual traction were not medically necessary.

The aforementioned information has been taken from the following guidelines of clinical practice and clinical references:

- ACR *Appropriateness Criteria™ for acute hand and wrist trauma.*
- American College of Radiology (ACR); 2001. 7p.
- Case-Smith J. Outcomes in hand rehabilitation using occupational therapy services. Am J Occup Ther. 2003 Sep-Oct;57(5):499-506.
- Nishimura A, et al. *Objective evaluation of sensory function in patient with carpal tunnel syndrome using the current perception threshold.* J Orthop Sci. 2003;8(5): 625-8.
- Weseley SA, et al. *Current perception: preferred test for evaluation of peripheral nerve integrity.* ASAIO Trans. 1988 Jul-Sep; 34(3): 188-93.

Sincerely,